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Organizational Change and Learning

A Strategic Approach for Managing Conflict in Hospitals: Responding to the Joint Commission Leadership Standard, Part 1

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The Joint Commission adopted new leadership accreditation standards, effective January 1, 2009, for conflict management in hospitals. One of the standards, LD.02.04.01, requires that “the hospital manages conflict between leadership groups to protect the quality and safety of care”¹ (Sidebar 1, page 60). This standard is one of numerous accreditation standards and alerts issued by The Joint Commission in recent years that address conflict and communication (Table 1, page 61). Taken together, they underscore the significant impact of relational dynamics on patient safety and quality of care, as well as the critical need for a strategic approach to conflict in health care organizations.*

To date, very little has been published describing hospital adoption of conflict management systems across the hospital enterprise.^{2,3} Most published approaches have focused on particular kinds of conflict,⁴ such as employee grievances,⁵ patient or family concerns about unanticipated outcomes of care (including alternative approaches for investigation, disclosure, apology, and prevention),^{6,7} end-of-life decision making for incapacitated patients,⁸ conflicts involving bioethics and the appropriate course of treatment for patients,⁹ and management of disruptive practitioners.^{10,11} This fragmented approach suggests that it is time for leaders to think about conflict management strategically. Developing a proactive mind-set and aligning effective conflict management approaches with the overall mission of the organization are the first steps in addressing conflict and its impact on the organization.

This two-part set of articles offers leaders a strategic framework for addressing conflict as an essential component of providing safe patient care, with an emphasis on methods for improving organizational conflict competence, particularly at the leadership level. In Part 1, we discuss components of a strategic approach to conflict, the move from conflict avoidance

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Article-at-a-Glance

Background: The Joint Commission’s leadership standard for conflict management in hospitals, LD.02.04.01, states, “The hospital manages conflict between leadership groups to protect the quality and safety of care.” This standard is one of numerous standards and alerts issued by The Joint Commission that address conflict and communication. They underscore the significant impact of relational dynamics on patient safety and quality of care and the critical need for a strategic approach to conflict in health care organizations. Whether leadership conflicts openly threaten a major disruption of hospital operations or whether unresolved conflicts lurk beneath the surface of daily interactions, unaddressed conflict can undermine a hospital’s efforts to ensure safe, high-quality patient care.

Developing a Strategic Approach to Conflict Management: How leaders manage organizational conflict has a significant impact on achieving strategic objectives. Aligning conflict management approaches with quality and safety goals is the first step in adopting a strategic approach to conflict management. A strategic approach goes beyond reducing costs of litigation or improving grievance processes—it integrates a collaborative mind-set and individual conflict competency with nonadversarial processes.

Undertaking a Conflict Assessment: Conflict assessment should determine how conflicts are handled among the leaders at the hospital, the degree of conflict competence already present among the leaders, where the most significant conflicts occur, and how leaders think a conflict management system might work for them.

Conclusions: Strategically aligning a conflict management approach that addresses conflict among leadership groups as a means of protecting the quality and safety of patient care is at the heart of LD.02.04.01.

Sidebar 1. Hospital Leadership Standard LD.02.04.01

The hospital manages conflict between leadership groups to protect the quality and safety of care.

Elements of Performance for LD.02.04.01

1. Senior managers and leaders of the organized medical staff work with the governing body to develop an ongoing process for managing conflict among leadership groups.
2. The governing body approves the process for managing conflict among leadership groups.
4. The conflict management process includes the following:
 - Meeting with the involved parties as early as possible to identify the conflict
 - Gathering information regarding the conflict
 - Working with the parties to manage and, when possible, resolve the conflict
 - Protecting the safety and quality of care
5. The hospital implements the process when a conflict arises that, if not managed, could adversely affect patient safety or quality of care.

This accreditation standard became effective as of January 1, 2009.

Source: The Joint Commission: *2011 Comprehensive Hospital Accreditation Manual: The Official Handbook*. Oak Brook, IL: Joint Commission Resources, 2010. Element of Performance 3 (“Individuals who help the hospital implement the process are skilled in conflict management. Note: These individuals may be from either inside or outside the hospital.”) was deleted from the standard.

to conflict engagement as a key aspect of accountable leadership, and how conflict assessment can serve as an initial step in designing approaches to managing conflict among leaders. In Part 2, we focus specifically on development of conflict competence among hospital leaders and offer practical approaches and recommendations for designing processes for managing conflict among hospital leadership groups.¹² Addressing conflict among leadership groups supports successful response to the other accreditation standards that address conflict and communication among hospital staff, patients, and family members (Table 1).

The Need for a Strategic Approach to Conflict Management

Conflict among hospital leadership groups can threaten the quality and safety of patient care. Whether leadership conflicts openly threaten a major disruption of hospital operations or whether unresolved conflicts lurk beneath the surface of daily interactions, unaddressed conflict can divert attention, energy, and resources away from a hospital’s efforts to ensure safe, high-

quality patient care. It can thus adversely affect how well the governing body and physicians fulfill their fiduciary duties^{13,14} to patients to act in patients’ best interests and “do no harm.” The purpose of conflict management is more than resolving individual disputes or decreasing costs: It is the foundation for providing safe, high-quality patient care.

Hospital cultures and dynamics are very different from other corporate and nonprofit businesses. Each hospital’s own distinct culture is imbued with the presence of various professional subcultures.¹⁵ The life-and-death nature of health care, the sense of altruism and doing good that motivates many of the professionals who enter the field, the unrelenting intensity of the work, and the high levels of education and expertise achieved by health professionals all contribute to creating highly charged, complex institutions. To provide high-quality, safe patient care in complex environments requires that health professionals attend to the quality of their interprofessional relationships, including the capacity to build trust and interact respectfully.¹⁶

In numerous recent studies, health professionals have identified high levels of conflict in the workplace. Much of that conflict is with one another,^{17,18} including conflicts between physicians and nurses or other hospital staff^{19,20}; between physicians and other physicians, administrators, and hospital staff^{21,22}; and between staff and managers or supervisors.²³ Conflict and breakdowns in teamwork and communication have a profound impact on health professionals and their ability to provide high-quality care.^{24–26}

The Joint Commission emphasizes the role and responsibility of hospital leaders to promote the quality and safety of patient care, and it expects leaders to develop approaches to manage conflict and ensure collaboration among health professionals.¹³ The Joint Commission’s *Sentinel Event Alert*, Issue 43, *Leaders Committed to Safety*, reinforces the importance of leadership’s commitment to the personal growth, collaboration, and openness necessary for safe care.²⁷ The *Alert* indicates that inadequate leadership was a contributing factor in 50% of the sentinel events reported to The Joint Commission in 2006. Appreciating the impact that unaddressed conflict has on safety and quality is an important aspect of a strategic framework for addressing conflicts among leaders.

Developing a Strategic Approach to Conflict Management

How leaders manage organizational conflict has a significant impact on achievement of strategic objectives.¹³ Institutional conflict management has been identified as a core, but often

Table 1. Selected Joint Commission Standards and Sentinel Event Alerts Addressing Conflict and Communication*

Standard or Sentinel Event Alert	Topic Addressed
LD.01.03.01, EP 7	Conflict among individuals employed within the organization
LD.02.02.01	Conflicts of interest involving leaders
LD.02.03.01	Regular communication among leaders on issues of quality and safety
LD.02.04.01	Conflict between senior leadership groups
LD.03.01.01, EP 5	Intimidating and disruptive behaviors
LD.03.04.01	Communication supporting quality and safety of care provided as needed to staff, independent practitioners, patients, families, and external interested parties
LD.04.02.01	Conflicts of interest involving independent practitioners and/or staff
LD.04.02.03, EP 1, 2	Conflicts involving staff and patients/families; ethical issues
LD.04.04.05, EP 6	Blame-free reporting of system or process failure or proactive risk assessment results
LD.04.04.05, EP 9	Support of staff after an adverse or sentinel event
MS.01.01.01 (effective March 2011), EP 3	Conflict involving medical staff proposals and bylaws
MS.01.01.01 (effective March 2011), EP 10	Conflict between medical executive committee and medical staff
MS.10.01.01	Fair hearing and appeal process of adverse medical staff privileges decisions
RI.01.02.01, EP 20, 21, 22	Disclosure of unanticipated outcomes
RI.01.07.01, EP 1	Patient and family complaints
<i>Sentinel Event Alert</i> , Issue 40	Behaviors that undermine a culture of safety
<i>Sentinel Event Alert</i> , Issue 43	Leadership committed to safety
<i>Sentinel Event Alert</i> , Issue 45	Preventing violence in the health care setting

* LD, Leadership; EP, Element of Performance; MS, Medical Staff; RI, Rights and Responsibilities of the Individual.

overlooked, responsibility of hospital boards to ensure the strategic objective of patient safety.²⁸ Aligning conflict management approaches with quality and safety goals is a necessary role for senior leaders—and is the first step in adopting a strategic approach to conflict management. A 10-point strategic framework for managing conflict is provided in Table 2 (page 62).

A growing number of Joint Commission standards are aimed at improving communication and conflict management (Table 1), making it imperative that leaders look at conflict from a strategic perspective across the enterprise rather than taking a tactical approach focused on addressing individual grievances. A strategic approach goes beyond the singular goals of reducing costs of litigation or improving processing of grievances. It is also more than just another organizational policy or risk management protocol. A strategic approach integrates a collaborative mind-set and individual conflict competency with nonadversarial processes. These processes provide the infrastructure for facilitating good interprofessional relationships, particularly among the leadership groups, so that conflict does not become a barrier to achieving organizational objectives.

Creating the expectation among leaders that conflict will be addressed and used for its creative potential creates an *align-*

ment of conflict management with organizational objectives. Reframing the importance of conflict engagement as a strategic means of accomplishing major initiatives and a leadership core competency is at the heart of the new Joint Commission standard for managing conflict among leadership groups.

Ironically, the health care industry has historically been more resistant to adoption of conflict management systems than other corporate settings.²⁹ Empirical data on adoption indicate that the cultural (leadership) view of conflict's impact on organizational performance is an indicator of an organization's willingness to develop such systems.³⁰ Unfortunately, conflict avoidance is the default mode for many health care professionals, which creates barriers to adoption of more comprehensive conflict management systems.

Cultures of Avoidance

A significant barrier to conflict management in hospitals is the culture of conflict avoidance that exists among health professionals. The prevalence of conflict suggests an underlying culture that tolerates unprofessional behavior and promotes conflict avoidance. Clinical staff and physicians repeatedly indicate that their decision to avoid engaging in conflict situations with colleagues is directly related to a fear of retaliation^{26,31} and

Table 2. A 10-Point Strategic Framework for Managing Conflict in Health Care Organizations*

1. Align approaches to conflict with overarching mission and strategic goals of the organization, e.g., safe patient care, quality care, healthy work environments.
2. Develop awareness of the prevalence and impact of conflict on ability to achieve strategic objectives and large-scale change.
3. Adopt collaborative mind-sets, shared mental models, and common language associated with conflict.
4. Assess the types and sources of conflict within the organization and resources for managing conflict, including those with conflict management expertise.
5. Develop conflict competency across the organization, particularly among leaders.
6. Design collaborative processes that allow for early and direct resolution of issues that are congruent with the values and needs of health professionals.
7. Integrate tiered approaches that offer informal collaborative options with more formal authority-based or legal procedures.
8. Reward good-faith attempts at conflict engagement and address all instances of retaliation.
9. Integrate conflict specialists within and external to the organization to support effective conflict engagement.
10. Evaluate the effectiveness of existing and newly designed processes and adapt them as needed.

* This framework represents best practices. Adapted from Lipsky D.B., Avgar A.C.: Toward a strategic theory of workplace conflict management. *Ohio State Journal on Dispute Resolution* 24(1):143–190, 2008 (reference 37); Mayer B.: *The Dynamics of Conflict Resolution: A Practitioner's Guide*. San Francisco: Jossey-Bass, 2000; Robinson P., Pearlstein A., Mayer B.: DyADS: Encouraging "Dynamic Adaptive Dispute Systems" in the organized workplace. *Harvard Negotiation Law Review* 10:339–382, Spring 2005; Mayer B.: *Beyond Neutrality: Confronting the Crisis in Conflict Resolution*. San Francisco: Jossey-Bass, 2004 (reference 38); Costantino C.A., Merchant C.S.: *Designing Conflict Management Systems: A Guide to Creating Productive and Healthy Organizations*. San Francisco: Jossey-Bass, 1996; and Gerardi D.: *Conflict Training for Health Professionals: Recommendations for Creating Conflict Competent Organizations*. EHCCO White Paper, 2010. <http://ehcco.com/news.php> (last accessed Dec. 8, 2010).

a lack of backup by organizational leaders.³² Organizational field studies show that conflict avoidance undermines team relationships and that teams that default to avoidance also tend to cycle toward competitive approaches and then revert to avoidance when competing does not work.³³ Avoidant behavior presents in numerous ways and often results in deflection, delay, or denial of the conflict situation (Table 3, page 63).

Leaders who exhibit ambiguous responses to conflict send negative messages, create mistrust, and feed future conflict.^{34,35} Habitual conflict avoidance has been linked to increased personal stress over time, and replacing avoidance with open communication can improve relationships and personal health.³⁶

Recognizing when avoidant patterns exist and supporting effective engagement is a leadership responsibility. Effective conflict management systems can support the shift from cultures of avoidance to cultures of engagement.

Moving from Conflict Avoidance to Conflict Engagement

The Joint Commission stresses a collaborative approach to hospital leadership. It emphasizes an overarching expectation that the leadership groups work well together:

How well the leaders work together is key to effective organization performance, and the standards emphasize this. Leaders from different groups—governance, senior management, and the organized medical staff—bring different skills, experiences, and perspectives to the hospital. Working together means that leaders from all groups have the opportunity to participate in discussions and have their opinions heard.^{1(Leadership Chapter)}

The Joint Commission's emphasis on collaborative processes is consistent with emerging themes in the organizational field of dispute systems design (DSD), which provide a strong foundation for developing effective hospital conflict management processes.

During the past few decades, the DSD field introduced "alternative dispute resolution" (ADR) mechanisms to decrease the high financial and psychological costs of relying on litigation to resolve commercial and interpersonal disputes. These ADR mechanisms include formal arbitration and mediation, as well as more informal, early intervention options such as coaching and facilitation.

Today, DSD experts go beyond identifying ADR as a means of decreasing costs or efficient processing of disputes and stress the importance of linking an organization's conflict management systems to its strategic objectives.³⁷ In Standard LD.02.04.01, The Joint Commission has embraced this approach by expressly aligning conflict management with the goal of promoting safe, high-quality patient care. Experts also contrast dispute resolution with conflict management: "Whereas dispute resolution is reactive, conflict management is proactive: it requires managers to anticipate problems rather than simply to react to them."^{37(p. 149)} Conflict *management* is an overall approach to conflict that includes skill building, nonadversarial process design, and conflict resolution³⁸ (Table 2).

The term *conflict engagement* takes this proactive stance one step further. In this article, conflict engagement refers to the capacity to effectively enter into and address conflicts of various types, at various depths, and over differing time frames, rang-

Table 3. Manifestations of Conflict Avoidance

- Pretending to be confused about processes or issues; denying the impact of the situation or the significance of the issues
- Sending representatives to fight the battle for you; creating a policy that mandates a third party to address the issues rather than direct conversations
- Implementing a schedule or work assignment that separates the individuals who are in conflict without addressing the situation directly
- Making threats or using intimidating tactics to distance others (includes threatening to enlist an attorney or demonstrating disruptive behaviors)
- Using legal or administrative procedures to escalate a situation and move the focus off of the relationship dynamics or interests at stake
- Giving in to solutions too quickly so as to avoid further discussion, and then not following through with them; making superficial apologies to placate the other person in hopes that it will be enough to settle the situation
- Delaying the conversation or talking around the issue once the conversation is convened; deflecting the conversation to focus on irrelevant information or over-analysis of substantive issues without addressing the impact on the relationship

* Adapted from Mayer B.: *The Dynamics of Conflict Resolution: A Practitioner's Guide*. San Francisco: Jossey-Bass, 2000.

ing from short-lived interactions to more complex and protracted disputes.³⁹ An effective process will capture the benefits that constructive conflict can confer by signaling important dissenting voices and positive opportunities for reconsideration and redirection to improve overall operations. In systems that employ DSD best practices, “there is an *acceptance of conflict* as inevitable and natural: conflict is seen as an opportunity, not an obstacle.”^{40(p. 56)} Recognizing the need to “stay with conflict” and remain engaged over periods of time is a necessary mind-set for those who lead complex organizations.³⁹ Through illustrative vignettes, Table 4 (page 64) shows how leaders can proactively use a range of collaborative, conflict management techniques and processes in a variety of different situations that present the potential for conflict. A proactive approach to conflict includes developing personal conflict competency among all leaders; recognizing opportunities to incorporate conflict management approaches during major change initiatives; supporting engagement through use of internal and/or external conflict specialists; and integrating collaborative processes, including dialogue, consensus building, conflict training, appreciative inquiry, coaching, and mediation. These options for handling potential or actual conflicts are discussed in more depth elsewhere.¹²

Defining “Leadership Groups”

Standard LD.02.04.01, Element of Performance (EP) 1, specifies that “senior managers and leaders of the organized medical staff work with the governing body to develop an ongoing process for managing conflict among leadership groups” (Sidebar 1). The three leadership groups that the accreditation standard identifies are (1) senior managers (senior administration), (2) the organized medical staff, and (3) the governing body.¹ Representatives from these three leadership groups are thus the primary participants in designing the conflict management process.

GOVERNING BODY

According to the most basic rule of corporate governance, the governing board has ultimate responsibility and authority for the governing of a corporation. As legal liability has increased for hospitals for the actions of physicians and administrators in recent years, there has been increased effort to attract knowledgeable board members and to foster real oversight by hospital boards. Reflective of the increasing seriousness of the board’s governance responsibilities, the revision of Standard LD.01.03.01 highlights this fundamental legal principle of corporate governance: “The governing body is ultimately responsible for the safety and quality of care, treatment, and services.”¹

MEDICAL STAFF

Typically, the organized medical staff provides the leadership for the medical staff in a hospital. The medical staff consists of the physicians who are given “privileges” to attend patients at the hospital. Physicians must apply for these privileges, undergo a formal credentialing and privileging process of review by their medical staff peers, and be recommended for privileges by the medical staff’s executive committee. The governing board has the ultimate authority to grant or deny staff privileges. With increasing litigation concerns, boards have been more robust in their reviews of medical staff privileges.

Historically, most medical staff members have been independent licensed practitioners rather than employees of the hospital. Consisting largely of independent practitioners, the medical staff does not “report” to anyone in the administration of the hospital. In some hospitals, the medical staff (through its medical executive committee) may have a dotted “communication line” to the CEO, but usually the medical staff has no formal accountability to anyone except the governing board,¹³ and, individually, to practitioner licensing authorities. EP 6 of Standard LD.01.05.01 flatly states, “The organized medical

Table 4. Vignettes Illustrating Hospital Leadership’s Proactive Responses to Potential Conflict

Leadership Development	Health system executives and board leadership anticipate the need for conflict coaching as part of the onboarding process for new leaders and make it a part of professional development during the first year in new leadership roles.
Practice Management	Knowing the potential divisiveness of proposed changes to reimbursement and call time, executives approve a structured dialogue process with an in-house facilitator to develop recommendations from stakeholders prior to implementation of the new structure.
Proposed Merger	Board members anticipate conflict associated with a proposed merger between two physician groups that provide care to the same service line, and they enlist the help of a mediator to work with the two physician groups, the hospital administration, and board liaisons to develop consensus around governance, quality oversight, ownership rights, and so forth.
Centralizing Conflict Management	Recognizing a growing need for an internal conflict specialist to assist with recurring conflicts among the staff members, physicians, and management, the administration convenes a process to design an internal Conflict Management Center to provide ombuds services, mediation, and coaching and to collect data to be used for improving systems issues that may be leading to conflict and impacting patient care.
Labor Strike	Following a difficult strike, administrators and board leaders make use of facilitators and crisis counselors to assist with reentry and reconciliation between administration, management, physicians, and staff.
Clinical Protocols	Recognizing the need for improved communication among department chairs in three service areas (cardiology, surgery, and radiology), leaders use an external mediator to facilitate conversations regarding development of protocols for use of a new CT scanner and to create a governance structure for a new Cardiac Center of Excellence integrating the services of the three departments.
IT System Implementation	Administrators anticipate the need for a conflict management process associated with implementation of a new clinical IT system and develop a facilitated process for escalating issues and resolving conflicts between senior operations team, the IT vendor, the IT department administration, the physician leadership, and the board.
Succession Planning	Anticipating the need to address generational conflicts and succession planning, the executive team from the hospital and the organized medical staff leadership work together to develop a training program supplemented by follow-up coaching to cultivate conflict competence, prepare up-and-coming leaders, and support smooth transitions.
Collaborative Relationships	Recognizing that physician leaders were coming to board members with increasing frequency requesting decisions or support for positions related to hospital operations, the board chair requests a conflict assessment be conducted by an external conflict specialist to identify a process for better communication, trust building, and consensus among the three groups.

* CT, computerized tomography; IT, information technology.

staff is accountable to the governing body.”¹

The traditional organizational structure—a semi-independent, self-governing medical staff without accountability to senior administration and sometimes with only grudging acknowledgment of responsibility to the governing board—has historically created considerable opportunity for conflict. Although it is legally clear that the ultimate responsibility and authority for medical staff bylaws, medical staff privileges, and other medical staff matters rest with the governing body, it will require collaboration to work effectively with medical staffs accustomed to their independence and relative autonomy.

SENIOR ADMINISTRATION

The persons considered to be senior administration vary from hospital to hospital, but they typically include the presi-

dent/CEO), the chief financial officer (CFO), the chief operating officer (COO), the chief medical officer (CMO), and the chief nursing officer (CNO), as well as directors/vice presidents of various other offices, such as legal affairs, risk management and quality control, pharmacy and other ancillary clinical service areas, human resources, development and public relations, and government affairs. It may typically be someone from the quality, risk, legal, or human resources departments who will draft the initial policy in response to the new leadership standard. The conflict management expertise of this individual will greatly affect the initial framework for the policy and process.

Although the EPs under Standard LD.02.04.01 provide that the “governing body approves the process for managing conflict among leadership groups,” they also emphasize that the senior managers and medical staff leaders “work with” the governing

Sidebar 2. Representative Types of Conflicts Among Leadership Groups

Case A: Conflict Between Medical Staff and Governing Body

The medical staff of a small community hospital owned by a national parent company determined that it no longer had any bargaining power with the hospital governing body regarding issues related to governance, patient care delivery, quality concerns, and assumption of financial risk. There was turnover in executive team leadership at the community hospital. The medical staff executive committee determined that it could no longer maintain good relations with the medical staff at large because of continued "take-aways" by the national board of directors of the large health system. As a consequence, the community physicians pooled their resources and executed a plan to build a competing hospital in the community in an effort to provide better care and gain leverage.

Case B: Conflict Between Medical Staff and Senior Administration

The CEO of a growing regional health system began his tenure with a collaborative approach that was valued by the medical staff, which was open to changes that involved the expansion of the growing network of referring physicians and some integration of physicians as employees of the health system. Over time, a small contingent of the independent medical staff felt that their interests were not represented and that they were being forced out. They believed that their only option was either to become employees of the health system or lose market share. The medical staff held two votes of no confidence in the CEO, and he was subsequently let go from his position despite several years of successful growth and market expansion.

Case C: Conflict Between Senior Administration and Governing Body

A well-respected academic medical center found itself facing a strike by staff nurses on the heels of a costly demerger with another institution. The nurses were angry that they had made concessions for several years to enable the organizations to merge, despite much opposition to the decision. The hospital administration did not appreciate how much their relationship with the nurses and their union representatives had deteriorated due to their focus on the demerger and other pressing issues. As a result, the nurses went out on strike for nearly three months, further devastating the resources of the organization and impacting its public reputation. The governing body was extremely unhappy with the senior administration and shortly following the strike, a new team replaced the senior administrators.

body to develop the conflict management process (Sidebar 1). The process that the governing body ultimately approves ideally should be created by consensus among these groups. In practice, the input of the senior administrators and medical staff leaders should be sought and vetted before the governing body adopts any process. It is essential that leaders of the organized medical staff be a part of the team that designs and implements a conflict management process for the leadership groups because many physicians desire autonomous authority over medical care and often balk at what they perceive as interference from nonclinicians.^{41,42}

Types of Conflict Addressed by the Standard

Although each hospital setting is unique, the primary areas of conflict among the three leadership groups which have been often reported in the literature and observed directly by the authors include those described in Sidebar 2 (above). The depicted cases represent fairly large disputes that resulted from a breakdown in collaborative work relations. The scale of the conflicts that occur at the leadership level can have a profound impact on patient care and the viability of the organization as a whole. Adoption of proactive approaches such as those represented in Table 4 could have led to different outcomes in each of these cases.

MEDICAL STAFF/GOVERNING BODY CONFLICTS

The organized medical staff has historically regarded itself as self-governing within the hospital. It has its own set of medical staff bylaws that govern the conduct of medical staff members, and historically these bylaws have been adopted and enforced separately from the hospital bylaws adopted by the governing board. Conflicts arising from the existence of two sets of bylaws with differing scopes of responsibility and enforcement have long plagued hospitals. Variations in employment status—including independent practitioners, faculty practice groups, and employed physicians—further add to the complexity. The Joint Commission's recently released standard MS.01.01.01 acknowledges the potential for these conflicts involving the organized medical staff and, in EP 3, expressly refers back to the leadership's conflict management process described in the leadership chapter.*¹

Examples of the issues that would benefit from conflict management between the medical staff and the governing board are as follows:

- Medical staff membership, discipline, and the granting and termination of medical staff privileges
- Governance issues, including bylaws, quality oversight, and physician well-being

* The new Standard MS.01.01.01 (formerly MS.1.20) goes into effect on March 31, 2011.

- Capital allocation
- Access to technology
- Addition and elimination of service lines
- Strategic business decisions, including mergers, joint ventures, and exclusive contracts
- Development of accountable care models and medical homes

MEDICAL STAFF/SENIOR ADMINISTRATION CONFLICTS

Conflicts between medical staff and administration are virtually a daily occurrence. Balancing the interests of the hospital with those of the physicians, particularly in the current reimbursement environment, creates a constant tension. Effective management of these conflicts has an impact on the longevity of the top administrators. One hospital CEO remarked, "If I have a problem with my board, I can resolve it. But if I have a problem with doctors and they tell other influential doctors, I better dust off my resume."^{42(p. 5)} Cohn states, "Although, publicly, healthcare leaders tell me that they serve at the pleasure of the board, privately, they tell me they serve at the pleasure of the medical staff as well."⁴² Despite this obvious power, physicians often believe that market pressures, shifting of financial risk, and overwhelming regulations keep them from having sufficient bargaining power with administrators. Fear of losing contracts for services and decreasing reimbursements fuel a number of conflicts between these two groups. Input into resource decisions, strategic positioning, and quality of care is desired by physicians.

Physicians and administrators live in different cultures, with different ways of thinking, communication styles, and approaches to conflict.^{15,42} Physicians have a deep drive to be successful and to protect their reputations, and they often feel that these are at risk in the chaotic environment in which trade-offs become necessary to balance competing interests and limited resources. In addition, productivity pressures are tremendous. These tensions create a barrier to effective engagement because of fatigue, lack of time to meet, and heightened stress responses, and added on top of poor conflict skills, they create a recipe for ongoing conflict. Cohn describes the "siege mentality" that exists in many hospitals where physicians and administrators have more to do than can be done in a day and lack control over interruptions, delays, and crises.⁴²

Examples of the issues that require conflict management between the medical staff and the administration are as follows:

- Interdepartmental disputes
- Physician-nursing staff relationships, particularly as they affect staffing and patient care

- Acquisition of technology
- Creation of standardized practice protocols

GOVERNING BODY/SENIOR ADMINISTRATION CONFLICTS

With an obligation toward the safety and quality of patient care, the governing body is accountable for ensuring that conflicts are addressed early so as not to put the organization or patients further at risk. It may be difficult for board members to know fully what is happening until a conflict has escalated to the level of a formal dispute or imminent crisis. Situations can occur where there is poor management of conflict by senior executives, but no information is given to the board, because those reporting to these individuals often fear retaliation. Alternatively, the medical staff may bring disputes to the board when it feels the administration is not responding to its needs. In addition, the board itself may have unaddressed conflicts among its members, which may reflect intraboard tensions or polarized positions within the community that a hospital serves. Such conflicts at the governing board level could lead to its inability to make timely decisions affecting important proposals of senior management or the medical staff. Developing a mechanism for monitoring the relationships among board members, executive team members, the medical staff leadership, and others provides an opportunity to be proactive rather than to address conflict only in the midst of high-stakes, high-emotion situations.

Examples of the issues that are likely to create tension or conflict between the governing board and senior management are as follows:

- Budgets and financing
- Priorities and annual goals-setting
- Processes for implementation of strategic plans
- Senior management personnel decisions
- High-stakes contracting decisions, such as building expansion or equipment purchases
- Large-scale changes (for example, implementing clinical information technology systems)
- Regulatory oversight
- Conflicts of interest
- Union conflicts
- Issues with the potential for legal liability of the hospital or individuals in the hospital

Undertaking a Conflict Assessment

Alignment with strategic objectives, awareness of the impact of conflict, and adoption of models and common language associ-

Table 5. Sample Conflict Assessment Questions

Substantive (Resource) Issues	Procedural (Structural) Issues	Relational Dynamics	Contextual Issues
<ul style="list-style-type: none"> ■ What resources are available for implementing a conflict management process? ■ Who has sufficient conflict management expertise to design and/or implement such a process for the leadership groups? ■ What are the most significant types of conflict that occur among the leadership groups? Are there recurring patterns that you have noticed? ■ Do the patterns emerge from personalities or from sensitive subject matters? ■ Has the CEO or governing board chair set a tone or expectation that there are no conflicts (and so they may be festering below the surface)? 	<ul style="list-style-type: none"> ■ What is the current process for addressing conflict among leaders? ■ How often is the process used? ■ How effective is the current process? ■ What works best for managing conflict among leaders at this organization? ■ What is the time frame for developing the new process and implementing it? ■ What aspects would an ideal process include? ■ Is there a process for a "sit down"? ■ To what extent is collaborative problem solving used? ■ Does one of the leadership groups (or individuals within them) exercise the power to resolve conflicts more or less unilaterally? 	<ul style="list-style-type: none"> ■ How would you characterize the current relationships among the three leadership groups? Within each group? ■ Describe how conflict has been managed respectfully among leaders in the past. ■ How has retaliation been addressed in the past? ■ Who would you trust within the organization to help you manage a difficult conflict? ■ Are there particular individuals who are at the heart of most major conflicts? ■ Do people deal with each other directly or look for ways to defer addressing the conflict to others? 	<ul style="list-style-type: none"> ■ Are there any current significant disputes among or within the leadership groups that could impact the design process? If so, what are they? ■ What works? When conflicts are effectively addressed, what has enabled that to go well? ■ What strengths does your leadership team possess that you can build on? ■ Have there been times when the three leadership groups have worked well together? What has changed? ■ Are there any upcoming projects or organizational changes that could escalate current conflicts?

Adapted from Mayer B.: *Beyond Neutrality: Confronting the Crisis in Conflict Resolution*. San Francisco: Jossey-Bass, 2004; and Costantino C.A., Merchant, C.S.: *Designing Conflict Management Systems: A Guide to Creating Productive and Healthy Organizations*. San Francisco: Jossey-Bass, 1996.

ated with conflict represent significant undertakings that serve as the foundation for the design of conflict management processes. Conflict assessment builds on this foundation to determine readiness and gain insight from the stakeholders. An assessment identifying how conflicts are currently handled among leaders, the extent to which the hospital's current conflict management system complies with the Joint Commission leadership standards, how often the current process is used, and the extent of satisfaction with it provides useful information for the process design team. How conflict is currently handled among leadership groups varies significantly across hospitals, depending on size, geography, leadership styles, and the culture of each institution. It is not uncommon for people to be unaware of any process or to cite "chain of command" as the most-used option. All organizations have a conflict management system of some type; the inquiry is whether it is functional and constructive rather than representative of dysfunctional habitual responses or destructive approaches to conflict.

Conflict assessment should be respectful, discrete, and efficient. The assessment should first determine how conflicts are

handled among the leaders at the hospital. Second, the assessment should determine where the most significant conflicts occur—within or between which leadership groups? Is there a current major conflict occurring that could affect the collection of data or divert attention from the creation of a conflict management process? Patterns of conflict can provide good insight into how best to design the process. Third, the assessment should measure the degree of conflict competence that may already be present among the leaders, their motivation to develop and use a conflict management system, and the availability of resources.^{40,43} Finally, the assessment should uncover how leaders think a conflict management system might work for them. The assessment should encourage the participants to make suggestions and recommendations, as well as to provide their perceptions about the feasibility of alternatives. Table 5 (above) outlines some sample questions that are typical in a conflict assessment. A conflict assessment typically looks at four domains and incorporates open-ended questions to collect insights and perspectives from a range of individuals.

PROCESS FOR GATHERING INFORMATION

A three-pronged approach to undertaking the assessment is recommended. First, there should be personal, confidential interviews with several key representatives from each of the leadership groups to determine the current approach to conflict, what works well, who is involved in dispute resolution, and where the “land mines” might be in the particular institution.

Second, from these interviews, an anonymous questionnaire can be distributed to all members of the leadership groups to delve more broadly and deeply into the current state of affairs for handling conflicts among the leaders. Ensuring anonymity is important to elicit honest responses; the only identifying characteristic on the questionnaire should be membership in one of the leadership groups. This allows for evaluation of differences in perspectives about conflict among the groups and identification of any barriers to implementing a collaborative approach. Third, validating what has been learned from the interviews and questionnaires to clarify understandings and to ensure that the assessment provides an accurate and complete picture is useful. This can be done through focus groups and individual follow-up interviews. A report of the results reflecting the general issues and concerns, as well as the preferences and the insights of the participants, should be prepared and delivered to the board chair, CEO, and CMO for review. On the basis of the data, the process design can be initiated.

CONFLICT SPECIALISTS

Although not required by The Joint Commission, it may be helpful for leaders to enlist the help of a conflict specialist with both health care and conflict management expertise to conduct the assessment.^{39,40} Hospitals may have an understandable desire to save money by doing the assessment internally, but the nature of this inquiry is very sensitive. Despite all good intentions, members of each of the three leadership groups are likely to have concerns or agendas that could interfere with their ability to conduct objective and truthful information gathering. Appointing someone internally who is not a member of one of the leadership groups could put that person in a potentially untenable situation of having to ask sensitive questions of the leaders or having to forego the questions, jeopardizing the ultimate utility of the assessment. Adequate time to conduct a meaningful assessment is also a consideration.

An outside conflict specialist without an investment in the current state of affairs and without a history with the individual leaders is better able to remain neutral, ask tough questions, ensure confidentiality, give genuine feedback, and make tailored suggestions for process design. Such consultants typically

work as mediators or teach within dispute resolution programs in academic settings. They are well versed in conflict processes and conflict theory. Whether using an internal or external resource, getting direct information from representatives of each group is key.

CUSTOMIZING THE APPROACH TO CONFLICT MANAGEMENT

For expediency and cost considerations, leaders may be tempted to curtail the entire assessment step and ask the hospital’s legal counsel simply to draft a policy to comply with the leadership standard and send it around for review and sign-off to all the leadership groups. The danger of this approach, and of even simply downloading a preformatted policy from the Internet, is that the policy will not have input from the various groups, it will not reflect the current challenges or what works well, it may look just like the traditional adversarial approach to conflict that is already in place, and it will likely get shelved and never used. A well-designed conflict management policy requires careful, individualized tailoring to an institution’s unique needs, resources, and culture, and it should reflect the results of a complete assessment.

Conclusion

Managing conflict is a necessary component of providing safe, high-quality patient care and a necessary role for health care leaders. Conflict among leadership groups can have a direct impact on the safety and quality of care provided. Strategically aligning a conflict management approach that addresses conflict among leadership groups as a means of protecting the quality and safety of patient care is at the heart of the Joint Commission leadership standard. **J**

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